Idaho HCBS, (Home and Community Bases Services), Medicaid

Orientation Guide

Medicaid Programs
Part II

Idaho Department of Health and Welfare
Division of Medicaid
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IDAHO DEPARTMENT OF HEALTH & WELFARE

Introduction:

This Idaho HCBS Medicaid Provider Orientation Guide was developed to assist Home and Community Based Services Waiver and Personal Care Service agency applicants better understand Medicaid Program requirements.

Part I of the Orientation Guide provides a 12 chapter introduction to Idaho Medicaid and related topics.

Part II of the Orientation guide defines specific Medicaid programs offered in Idaho.

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Chapter 13 The Medicaid Aged and Disabled Waiver

13.1 What is the Aged and Disabled Waiver?

"Home and Community Based Services" (HCBS) Waivers: When states wish to receive federal financial assistance for services provided in a setting such as the participant's own home or a community setting, the state must first obtain a waiver from the federal Centers for Medicare and Medicaid Services (CMS). Thus, Home and Community-Based Services (HCBS) waivers are options for states to fund community services provided to eligible people who would otherwise require institutionalization.

In requesting a waiver, states propose a program specific to the population they want to serve. States have the flexibility to design each waiver program and select the mix of services that best meet the needs of the population being served. In developing the proposal, states are required to provide CMS with a number of assurances before the waiver is approved. These assurances include:

- The waiver participant must be eligible for institutional level of care
- The waiver participant must meet cost effectiveness criteria (the cost of care in the home/community cannot exceed the average cost for care in an institution)
- The waiver program must offer sufficient services for a waiver participant to safely remain in his/her home

The Aged and Disabled Waiver, (A & D Waiver)

In 1996, Governor Phil Batt's Medicaid Reform Council held public meetings throughout the state. The public told the Council what they liked about Idaho Medicaid, and what they did not like.

Individuals needing long-term care, including persons who are elderly or disabled, asked for more options to suit their needs. They asked for more flexibility in the services they can receive. They also asked to be able to stay in their own homes for as long as possible.

At that time, Idaho's long-term care system did not give individuals many choices. Basically, there were two options. On one end of the continuum of care was personal care services or PCS and on the other end was institutions. There was nothing in between.

Following the public meetings, the Medicaid Reform Council put together a set of recommendations for the Governor who, in turn, developed his Medicaid reform Package. In this package, he asked the Department of Health & Welfare to create a system of care emphasizing home and community-based services for Idaho's adults who are aged and disabled.

In response to this directive, the Department established an Internal Steering Team to guide the process of developing affordable home and community-based care. While the Internal Steering Team directed the process, six sub-teams with a much broader representation of consumers, providers, advocates, associations, and state staff developed the options in the Home and Community Based Services (HCBS)-A & D waiver.

13.2 Who does the A & D Waiver Serve?

The waiver serves participants who are:

- 18 years or older and who are elderly or physically disabled
- Can be safely maintained in their homes or community with the services provided

13.3 What are the eligibility requirements?

- Must meet financial eligibility-income and assets at or below the limit
- Meet nursing facility level of care as determined by the Uniform Assessment Instrument
- Must need and receive a waiver service at least every 30 days

13.4 What services are available?

- Adult Day Care
- Specialized Medical Equipment-equipment not covered by Medicaid

- Case Management
- Homemaker services
- Respite Care-for non-paid caregivers
- Environmental Accessibility Adaptations-modifications to the home
- Skilled Nursing
- Non-Medical Transportation
- Chore Services
- Personal Emergency Response System
- Companion Services
- Attendant Care
- Adult Residential Care-a daily rate that "bundles" services in an assisted living situation
- Home Delivered Meals
- Consultation-education for the caregiver on the specific needs of the participant
- Psychiatric Consultation

Detailed service definitions can be found in Idaho Administrative Code 16.03.09.673-695, "Rules Governing the Medical Assistance Program."

http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

13.5 What Provider Types can serve Aged and Disabled Waiver Participants?

Providers must be a Residential Assisted Living Facility (RALF), a Certified Family Home (CFH), or a Personal Assistance Agency.

- RALFs are licensed by the Department's Bureau Facility Standards and must meet all requirements found in IDAPA 16.03.22

  http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

- CFHs are certified by Regional Medicaid Services and must meet all requirements found in IDAPA 16.03.19.

  http://www2.state.id.us/adm/adminrules/rules/idapa16/0319.pdf

- Aged and Disabled Waiver agencies must meet the requirements found in IDAPA 16.03.09.664.

  http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

Agencies must sign the Medicaid Provider Agreement. Additionally, they must sign the Additional Terms-Personal Assistance Agency, Aged and Disabled Waiver provider agreement, & Provider Agreement for Personal Care Service Providers.

13.6 Aged and Disabled Waiver
ADDITIONAL TERMS AGREEMENT:
For **Aged and Disabled Waiver Agencies**, an Additional Terms Agreement must also be signed and all requirements met by the provider. (This agreement is not required for Certified Family Home Aged and Disabled Waiver Providers, Residential Assisted Living Facility Aged and Disabled Waiver Providers, and certain vendors).

Agencies will be required to write and submit specific policies and procedures, programs, and implementation plans and submit them to the Department with their Medicaid Provider Application. These documents must receive Department approval before the application will be processed and approved.

Following are selected Additional Terms Agreement sections that are further defined to assist the Provider/Applicant in assembling the required documentation:

13.7 Training: (Additional Terms Section A-3).
"The Provider shall ensure that direct service providers receive orientation and training to meet the specific needs of the participant(s) to whom they are assigned work duties."

- It is the agency's responsibility to insure that all direct service providers have the necessary skills to care for Medicaid participants safely and effectively. Before a direct service provider can be assigned to care for a participant, the Provider Agency must insure that the direct service provider has the specific skills and competencies to meet the participant's care needs. (This requirement is further defined under Additional Terms Requirement A-7.8 on page 55).

  The provider must submit a plan and curriculum to demonstrate that direct service providers receive the proper training to meet the needs of Medicaid participants.

13.8 Quality Assurance: (Additional Terms Section A-5): ***"The provider is responsible for the development and implementation of a Quality Assurance Program which assures service delivery is consistent with applicable rules..."*** The Provider Quality Assurance Program must address the following:

- ***"A participant's implementation plan should be modified when there are changes in circumstances, abilities, or a re-assessment to ensure that public funds are expended for appropriate services in the most cost-effective manner,*** (Additional Terms Requirement A-5.1)"
  Define a process of participant care plan review and modification to insure accurate and appropriate care is being delivered. In addition to reporting significant increases in care needs, how will the agency insure that participant decreases in care needs will be reported to the Department? How will the Provider Agency measure quality assurance in this area?

- ***"The Provider informs each participant or guardian of the services to be received,*** (Additional Terms Requirement A.5.2)***."***
  Define the process that will be used to inform participants and/or their guardians of services the participant will receive from the Provider Agency. This process will involve the participant's review and approval of the care plan. How will the Provider Agency measure quality assurance in this area?

- ***"The Provider, its employees and subcontractors interact with participants in a respectful manner,*** (Additional Terms Requirement A.5.3)***."***
  Describe how the Provider Agency will insure that employees and subcontractors interact respectfully and professionally with Medicaid participants. The Provider Agency may develop policies and provide training in this area. This requirement might be measured during employee performance evaluations and written into subcontractor contracts. The Provider Agency might conduct participant satisfaction surveys that specifically measures respectful and professional interactions. How will the Provider Agency measure quality assurance in this area?

- ***"Provider interventions promote participant empowerment and choice. Participants are recognized as primary decision-makers in accessing any and all services, unless an appropriate guardianship has been established by a court,*** (Additional Terms Requirement A-5.4)***."***
  How will the Provider Agency empower the participant and make them aware of their choice regarding care and service provision? How will the Provider Agency measure quality assurance in this area?

- ***"Services are provided at a time and location that is convenient, acceptable and suitable for the participant and the participant's team, and are coordinated and consistent with all other services the participant is receiving,*** (Additional Terms Requirement A-5.5)***."***
  Service delivery must be discussed and agreed upon by the participant and the participant's care team. These issues should be discussed with the participant and documented in the participant's treatment planning process. How will the Provider Agency measure quality assurance in this area?

- ***"The Provider's decision to accept or continue services for a participant is based on the provider's ability to meet the needs of the participant,*** (Additional Terms Requirement A-5.6)***."***
  The Provider will document how they will screen participant care needs to insure the Provider has resources and qualified staff to render safe and effective care to participants. How will the Provider adjust for changes in participant care need over time? How will the Provider Agency measure quality assurance in this area?

- ***"The Provider schedules services to insure that the implementation plan for this service is developed and implemented effectively,*** (Additional Terms Requirement A-5.7)***."***
  Document how the Provider will insure that the participant's scheduled care services are effectively met. How will the provider Agency measure quality assurance in this area?

- ***"The Provider conducts a quality assurance program which includes quarterly audits of services, site***

visits, participant satisfaction, and annual professional credential and competency review. Provider shall implement a Quality Improvement plan for any deficiencies noted, (Additional Terms Requirement A-5.8)***"***
Provider must present a written quality assurance program containing specific policies and procedures detailing the program. The procedures will define how the agency will collect quarterly data to insure that appropriate and quality services are being provided to participants. The quality assurance procedure will include documented quarterly participant home site visits and participant satisfaction surveys. Annually, the Provider will conduct credential and competency reviews to insure that employees continue to meet all qualification requirements of the program. As the Provider documents deficiencies or quality improvement needs during audits and reviews, the Provider will develop a written plan and correct or address deficiencies. All collected data and quality improvement actions will be reviewed by the Department during scheduled review.

- "***The Provider informs the participant about the participant's rights, the availability of protection and advocacy services,*** (Additional Terms Requirement A-5.9)***"*** The Provider must develop a procedure to insure that each participant is informed of participant rights, availability of adult protection services, and advocacy services. This information should be documented in participant files.

- ***"To the maximum extent feasible, the range of services must be provided by a regularly assigned employee or employees,*** (Additional Terms Requirement A-5.10)***"*** How is the Provider assuring there is caregiver consistency for participants? How will the provider Agency measure quality assurance in this area?

131.9 <u>Financial Stability</u>: (Additional Terms Section A-6): ***"The Provider shall provide the Department business information and evidence of financial stability and capability to fund payrolls and other business costs. The***

provider shall provide documentation that demonstrates the agency's business integrity…"

- At the time of application and during subsequent reviews, the Provider agency must make available business information and evidence of financial stability demonstrating that the Provider is financially stable and capable of funding payrolls and other business costs.

- The following documentation is required:
  - A list of Corporate Officers or Principles
  - Date the Provider agency was established
  - Business ownership definition, (public company, subsidiary, partnership, etc).
  - List of employees identified by employee classification and/or type of work assignment.
  - In order to demonstrate financial integrity, the Provider must submit financial documents such as balance sheets, statements of income, statements of change in financial position, auditor's reports, and/or annual reports if the agency issues them, (submit the last 2 annual reports issued). Other financial documentation will be accepted if it adequately demonstrates the Provider agency's financial integrity.

13.10 Policies and Procedures: (Additional Terms Section A-7): ***"The provider shall provide to the Department policies and procedures…"***

- The Provider Agency will develop specific policies and procedures and attach the required documents to the Medicaid Provider application. The submitted policies and procedures will be reviewed by the Department for accuracy and appropriateness before the application will be approved. Additionally, the Provider Agency will insure that policies and procedures are reviewed and updated on a regular basis and will be reviewed by the Department during scheduled agency reviews. It is recommended that the Provider Agency have good knowledge and skills in developing and writing policy statements and procedures.

- ***"Personnel, including employee qualifications, duties, compensations, benefits, training and conduct,*** (Additional Terms Requirement A-7.1)***."*** This policy and procedure should address how the Provider

Agency will insure employees meet required skills and qualifications and what the employee compensation and benefit schedule includes. Providers will develop job descriptions which specifically detail employee qualification requirements and job duties and attach them to this policy. The policy must address how the Provider Agency will insure employees receive adequate training and what the Provider Agency standards of conduct are.

- ***"Standards for acceptance of participants, intake and admission procedures, and termination of services,*** (Additional Terms Requirement A-7.2)***"*** This policy and procedure defines the standards a Provider Agency will use to determine under what conditions it will accept a participant into services. The procedure will detail specifically how the Provider Agency will admit a participant into services. The policy/procedure also describes the circumstances participant services may be terminated.

- ***"Participant's rights and confidentiality,*** (Additional Terms Requirement A-7.3)***"*** The Provider Agency should review Chapter 8 of this Medicaid Provider Orientation Guide, "Advance Directives and Participant Rights," before constructing this policy/procedure. The policy/procedure must define how the Provider Agency will insure participants are aware of their rights. The Provider Agency will attach Participant Rights and Advance Directive documents it develops or uses to the policy. Additionally, the Provider Agency must comply with all state and federal confidentiality laws. The policy will define how the Provider Agency will educate employees about confidentiality laws, and how they will insure that participants are aware of their confidentiality rights. The Provider Agency will attach Release of Information Forms and Confidentiality Notices that it develops, to include staff training materials/curriculums, to this procedure.

- ***"How the provider will maximize participant choice and involvement in the selection, scheduling, direction, and evaluation of direct service providers,*** (Additional Terms Requirement A-7.4)***"*** The Provider Agency will develop a policy and procedure that specifies how the participant will be involved in planning and direction of their care. Specifically, the participant must

be included in the process of selecting direct service providers employed by the Provider Agency, and development of care schedules. The policy will further define how the participant will be included in evaluating direct service providers.

- ***"Participant and employee grievance procedures,*** (Additional Terms Requirement A-7.5)***"*** The Provider Agency will develop a policy/procedure that outlines how employees and program participants may file grievances. The policy should describe how employees and participants are made aware of the grievance procedure, how the grievance may be reported and to whom, and what steps the Provider Agency will take once a grievance is received. The Provider Agency will define under what circumstances it will notify the Department about certain grievances and resolution actions.

- ***"Scope of service provided and procedures for delivering services. This must include how the agency will accomplish A-5.10*** (Additional Terms Requirement A-7.6)***"*** This policy/procedure will define what specific Aged and Disabled Waiver services the Provider Agency will provide and how the services will be specifically delivered. The policy/procedure will also define how the Provider Agency will insure participant services are provided by regularly assigned employee or employees.

- ***"Emergency response to ensure participant health and safety. The provider must have a plan that demonstrates the capability of providing emergency back up and relief services to cover the essential service needs within a reasonable time frame*** (Additional Terms Requirement A-7.7)***"*** This policy and procedure will address how the Provider Agency and direct service providers will respond to a participant emergency to insure participant health and safety are protected. Additionally, the policy/procedure will outline how the agency will insure continuity of care and service delivery, within a reasonable time frame, when emergency back up and relief services are needed.

- ***"Description of how the agency will assure that all direct service providers meet the qualifications contained in the Provider Training Matrix and***

Standards for Direct Care Staff and Allowable Tasks/Activities (Additional Terms Requirement A-7.8).***"*** A copy of the "Provider Training Matrix" and "Standards for Direct Care Staff and Allowable Tasks/Activities" forms are attached to the Aged and Disabled Waiver Provider Application. The Provider Training Matrix lists required and contingent skills and abilities for specific types of Direct Care Staff. Competency for Standards 5-25 in the Standards list must be verified by a physician, registered nurse, occupational therapist, physical therapist, or other person with a professional degree or experience in specialized areas.

Verification of skill or knowledge can be documented in one of two ways. First, if the direct care person has previous experience delivering in-home care or has successfully completed a formal education/training program covering in-home and community based care, a detailed written or verbal explanation of the procedure can be the means of verifying competency. Secondly, if the direct care person does not have experience, then actual observation of demonstrated competency is required, meaning that the Provider Agency will insure direct care staff are able to perform care tasks that each participant they care for requires.

The policy/procedure must document how the Provider Agency will insure these standards are met and documented.

13.11 Transition of Participants: (Additional Terms Section A-8): ***"The Provider shall develop a transition plan and provide such notice to the participant as is approved by the Department when services are being terminated."***

- The Provider Agency will develop a policy/procedure that details the process by which participants will be notified when services are being terminated by the agency. The policy will define, at a minimum, under what circumstances services may be terminated, how the participant and Department will be notified, and notification/action timeframes. The policy will further identify how the agency will assist the participant with transition to insure that continuity of care, in certain cases, is not interrupted.

13.12 Records/Reports: (Additional Terms Section A-9): The Provider Agency is required to maintain certain records and report information on a regular basis to the Department.

- ***"Keep a list of all participants being served, and all employees, subcontractors or agencies, and submit it to the Department quarterly,*** (Additional Terms Requirement A-9.1)." The Provider Agency must submit a list of Medicaid participants that it is currently serving, and a separate employee, subcontractor/agency list to Regional Medicaid Services on a quarterly basis, (due no later than Mar 31, Jun 30, Sep 30, Dec 31 each year).
- ***"Keep progress notes/records of time, and tasks/activities performed by direct service providers and have them available to the Department during Quality Assurance reviews***, (Additional Terms requirement A-9.2)." The Provider Agency must document each item of service for which Medicaid payment is claimed, at the time it is provided. The records of these services must be kept for at least five (5) years after the date of services. The Provider Agency must provide immediate access to the records upon request from the Department, the U.S. Department of Health and Human Services or their agencies. These records may be reviewed and copied by these entities.
- ***"Keep annual evaluation reports and have them available to the Department during Quality Assurance reviews*** (Additional Terms requirement A-9.3)***."*** The Provider Agency will make all A.5 related quality assurance reports available to the Department during reviews.
- ***"Inform the Department within forty-eight (48) hours of any charges of criminal conduct, any accusation of fraudulent, negligent or abusive conduct, and any termination for poor performance by any employee, subcontractor or agent,*** (Additional Terms requirement A.9.4). The Provider Agency is responsible to inform the Regional Medicaid Services in writing when any agency employee has been criminally charged, an accusation of fraud, negligence, or abusive conduct has been made, or an employee, subcontractor, or agent has been terminated from service or employment by the Provider Agency for poor performance.
- ***"Report any suspected or observed fraudulent, negligent, or abusive conduct to the appropriate***

legal authority as required by rule or law, (Additional Terms Requirement A-9.5).***"*** Refer to Idaho Administrative Code 16.03.19.200-220 to review definitions and procedures regarding fraud, abuse and misconduct by providers and their employees. If a Provider Agency has reason to believe that fraudulent, negligent, or abusive conduct has occurred, it is required to contact the Department and other legal authority as required by rule/law, (eg., Law Enforcement, Commission on Aging, Child Protection, etc).

13.13 Subcontractors: (Additional Terms Section A-10): ***"The provider shall describe the extent to which subcontractors will be used, submit to the Department for review all contracts between the agency and its subcontractors, and have procedures in place to assure the work performed by the subcontractor is of high quality."***
The Provider Agency is responsible to develop a policy/procedure that identifies to what extent it will use subcontractors, and how the agency plans to monitor the contract, supervise, and insure that quality standards of service and care are being adequately delivered. The Provider Agency will submit copies of all subcontractor contracts and subcontractor qualifications to the Department for review.

Chapter 14 Home and Community Based Services: ASSISTIVE TECHNOLOGY/SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

14.1 What is Assistive Technology?

Assistive Technology is any item, piece of equipment or product system beyond the scope of the Medicaid state plan, whether acquired off the shelf or customized, that is used to increase, maintain or improve the functional capability of the participant. Assistive Technology can range from something as simple as a reacher, a cane, or a bathroom grab-bar to something as complex as life-support, supplies and equipment to support such systems, adaptive computer key board, augmentative communication device or durable and non-durable medical equipment.

14.2 Who does Assistive Technology serve?

This service is available to participants who are eligible for waiver Home and Community Base Service, (HCBS) and have a valid need for substantiated specialized medical equipment.

14.3 What are the eligibility requirements?

- Financially eligible
- Elderly who meet Nursing Facility Level of Care
- 18 years of age or older, who are physically disabled and meet Nursing Facility Level of Care.

14.4 What are the equipment requirements?

- Equipment or supplies must prove a direct medical or remedial benefit to the participant.
- Items must meet applicable standards of manufacture, design and installation

- Equipment must be the most cost effective to meet the participants' need identified in the UAI.

14.5 What Provider Types can provide this service?

Providers of specialized medical equipment and supplies must be enrolled in the Medicaid Program as a participating Medical Vendor Provider.

Chapter 15 Home and Community Based Services: HOME MODIFICATION

15.1 What is Home Modification?

Home Modification is any minor housing adaptation that is necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization.

15.2 What examples may Home Modification include?

- Installation of ramps, lifts
- Widening of doorways
- Modification of bathroom facilities
- Installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the waiver participant.

15.3 What does Home Modification Exclude?

- Adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair or central air conditioning.
- Modifications that increase the square footage of the home or items of replacement or repair that are the normal responsibility of the homeowner.

15.4 Who is eligible for Home Modification?

Elderly or Physically disabled participants, who are eligible to receive Home and Community Base Services, (HCBS), may request home modification.

15.5 Where may Home Modification take place?

- Permanent environmental modifications are limited to modifications to home owned by the participant or the participant's family and the home is the participant's principal residence.

- Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence.

15.6 What Provider Types can perform Home Modification?

- Provider of Home Modification must be enrolled in the Medicaid Program as a participating Medical Vendor Provider.
- Provider contractor must be willing to submit itemized bids for review/approval to RMS.
- Provider contractor must have the proper certification to perform service in accordance with state and local building, electrical and plumbing codes.

Chapter 16 Home and Community Based Services: PERSONAL EMERGENCY RESPONSE SYSTEM, (PERS)

16.1 What is a Personal Emergency Response System, (PERS)?

A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems.

16.2 Who is eligible for a Personal Emergency Response System, (PERS)?

- Adults authorized to received Home and Community Based services; and
- Participants who do not live in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, residential/assisted living facilities, or certified family homes; and
- Participants who rent or own the home, or live with unpaid relatives; and
- Participants who are alone for significant parts of the day; and
- Participants who have no caretaker for extended periods of time; and
- Participants who would otherwise require extensive routine supervision

16.3 What are the provider qualifications for a Personal Emergency Response System, (PERS) provider?

- Apply for and receive a provider number and enter into a written provider agreement through the Idaho Department of Health and Welfare.
- Demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards.

Chapter 17 Home and Community Based Services: HOME DELIVERED MEALS

17.1 What are Home Delivered Meals?

Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one, (1) to two, (2) meals per day.

17.2 Who is eligible for Home Delivered Meals?

- Adults authorized to receive Home and Community Based Waiver services; and
- Participants who do not live in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, residential/assisted living facilities, or certified family homes; and
- Participants who rent or own their own home; and
- Participants who are alone for significant parts of the day; and
- Participants who have no regular caretaker for extended periods of time; and
- Participants who are unable to prepare a balanced meal.

17.3 What are the provider qualifications for Home Delivered Meals?

- Apply for and receive a provider number and enter into a written provider agreement through the Idaho Department of Health and Welfare.
- Provide assurances that each meal meets one third, (1/3), of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized diet requirement; and
- Maintain Registered Dietitian documented review and approval of menus, menu cycles and any changes or substitutes; and
- Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three, (3), days per week; and

- Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; and
- Provide documentation of a current Idaho driver's license for each driver; and
- Must be inspected and licensed as a food establishment by the District Health Department.

Chapter 18 Home and Community Based Services: ADULT DAY CARE

18.1 What is Adult Day Care?

Adult Day Care is a supervised and structured daytime program that is offered outside the participant's regular residence. It may offer one or more of a variety of social, recreational, and health activities. This would include supervision for safety and assistance with activities of daily living.

18.2 Who is eligible for Adult Day Care?

- Adults receiving service through one of the participating HCBS waivers
- Participants who do not require continuous nursing assessment and intervention.

18.3 What are the eligibility requirements?

- Available to participants eligible for Home and Community Based Services.

18.4 What services are available? (May include but not limited to)?

- Recreational activities
- Maintenance of self-help skills
- Assistance with activities of daily living
- Arrangements for medical and dental services
- Provisions for trips to social functions
- Special diets

18.5 Adult Day Care Additional Terms Agreement

For Adult Day Care Providers, an Additional Terms Agreement must also be signed in addition to the Medicaid Provider Agreement and all requirements must be met.
Following are selected Additional Terms Agreement sections that are further defined to assist the Provider/Applicant in

assembling the required documentation, (for complete listing, review the Adult Day Care Additional Terms Agreement):

(A-2) Fire/Life/Safety Standards: The building standards in the additional terms apply to free standing structures that provide only Adult Day Care and are not a:

- Certified Family Home, (CFH)
- Residential Assisted Living Facility, (RALF)
- Developmental Disability Agency, (DDA)
- Nursing Facility or
- Hospital

The above entities must meet the requirements of their certification or licensure when providing adult day care.

If you are a provider that is not one of the above, you must, at a minimum, meet the requirements of a CFH if care is provided in a home.

18.6 Enrollment Criteria

Providers need to review participant's medical, social, and diet needs prior to admission to their program. It is important that there is adequate, trained staff to meet the level of care for each participant. Another consideration is the different needs of the participants in the adult day care and their compatibility. Can safe care be provided? Will the participants get along during the day?

18.7 Space and Accommodations Requirement

The space requirements apply to free standing structures that provide only Adult Day Care. Developmental Disability Agencies, Residential Living Facilities, Certified Family Homes, Nursing Facilities, and Hospitals must meet the standards in the IDAPA rules that govern those entities and give the requirements. Free standing structures must meet the standards in this agreement.

Chapter 19 Service Coordination for Personal Care Services

19.1 What is Service Coordination?

- Service Coordination is case management which assists Medicaid individuals in gaining, coordinating access to, and maintaining necessary care and services, (medical, social, educational, and other services), appropriate to the needs of the individual. Service Coordinators are expected to encourage participants and their families/guardians to learn to access and coordinate services without the assistance of a service coordinator if possible.
- Service Coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose. Participants are only eligible for one type of Service Coordination. If they qualify for more than one type, the participant must choose which one.
- A participant may receive up to eight, (8), hours per month of Service Coordination. Service Coordination must be prior authorized by the Department.

19.2 Who is eligible for Service Coordination for Personal Care Services?

- Adults who are authorized to receive State Plan Personal Care Services; or
- Adults authorized to received Home and Community Based Waiver services; and
- Participants who do not live in hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

19.3 What are the functions of the Service Coordinator for Personal Care Services?

Service Coordination reimbursed by Medicaid is a brokerage model of case management and does not include the provision of direct services. Service Coordination consists of the following functions:

- Linking the Participant to needed services; and
- Monitoring and coordination of services.

19.4 Only the following modes of providing services will be paid:

- Face to face contact between the Service Coordinator and the participant;
- Telephone contact between Service Coordinator and the participant, participant's service providers, family members, primary care givers, legal representative, or other interested persons;
- Face to face contacts between the Service Coordinator and the participant's family member, legal representative, primary caregivers, providers, or other interested persons; and
- Paperwork that is associated with obtaining certain needed services such as food stamps, energy assistance, emergency housing or legal services;

Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the services, or leaving messages.

19.5 What are the Provider Qualifications for a Service Coordinator?

- Apply for and receive a provider number and enter into a written agreement through the Idaho Department of Health and Welfare.
- Service Coordinators must be employees or contractors of an organized provider agency that has a valid provider agreement with the Department of Health and Welfare; and
- All Service Coordinators must have at least twelve, (12), months experience working with the population they will be serving and be supervised by a qualified State Coordinator; and
- All Service Coordinators must have a minimum of a BA or BS in a human services field or be a licensed registered nurse, (R.N.); and
- All Service Coordinators must pass a Department criminal history check.

Service Coordination agencies must provide supervision to the Service Coordinator employed by the agency. Agency supervisors must meet the following criteria:

- Master's degree in a health or human service field and one, (1), year experience with the population for whom they will be supervising services; or

Bachelor's degree in a health or human services field or RN and two, (2), years experience with the population for whom they will be supervising services.

Chapter 20 State Plan Personal Care Services

20.1 What is State Plan Personal Care Services?

- State Plan PCS is a program that delivers personal care services to eligible participants in their personal residence in order to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage individual choice, and to maintain community integration. Unfortunately, the State of Idaho plan and the PCS State plan are often confused when discussing 'state plan.'
- State Plan PCS is one of the many programs administered by the Department of Health and Welfare under the overall State Plan. The State of Idaho's State plan is a comprehensive written statement submitted to CMS describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, Code of Federal Regulations and other applicable official communication of the Department. The State plan contains all information necessary for Centers for Medicare and Medicaid Services (CMS) to determine whether the plan can be approved to serve as a basis for Federal financial participation in the State program.

20.2 Who does the State Plan PCS serve?

- Children who meet the medical necessity criteria for EPSDT services under IDAPA 16.03.09.536 may receive up to twenty-four (24) hours of PCS per day of service delivery under the State Plan option until their eighteenth (18)birthday. Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) provide early detection of medical and developmental problems. These expanded services for children were developed to meet the federal requirement that states cannot limit services to children if the service is medically necessary. From (18) years to twenty-one (21), service delivery is limited to a maximum of sixteen hours per week under the State Plan option.
- Adults, aged 18 years and older, who have been determined to be financially eligible for Medical Assistance as described in IDAPA 16.03.05 and have a medical condition that impairs

physical or mental functioning and independence are able to access the State Plan option.

20.3 What are the eligibility requirements?

- Participants must be Medicaid eligible.
- Participants must be able to be maintained safely and effectively in their own home or residence.
- Participants must have medical justification which is identified by conditions in the client that endanger life, cause pain, or cause functionally significant deformity or malfunction and there is no other equally effective course of treatment available or suitable for the client requesting the service which is more conservative or substantially less costly.
- A licensed physician or authorized provider must certify, in writing, that the services are medically necessary.
- An Assessment/Plan of Care, prepared by a Registered Nurse or Registered Nurse/QMRP (Qualified Mental Retardation Specialist) includes amount, type, and frequency of services to be provided and is signed and approved by the physician or authorized provider prior to the initiation of the services by the PCS provider.
- Participants are reassessed annually and as necessary for appropriate program participation, number of service hours, continued safety and effectiveness of their program.
- All services will be authorized by the RMS prior to payment for the amount and duration of services.

20.4 What services are available under PCS?

- PCS can be done by a CNA or non-CNA (called Attendant). If the participant is developmentally disabled there is an additional training requirement that the caregiver must meet. Services may include but are not limited to the following:

    - Personal care and hygiene including bathing, hair care, assistance with clothing and basic skin care.
    - Assistance with bladder or bowel requirements.
    - Assistance with ordinarily self-administered medications ordered by a physician.
    - Assistance with food, nutrition, and diet activities, meal preparation **IF** incidental to medical need.

- In addition to performing at least **ONE** of the above tasks, the provider may also perform the following services:

- Incidental housekeeping services essential to a participant's safety and health including linen change, rearranging furniture for participant safety, laundry and room cleaning. **Excluded** are cleaning and laundry for any other occupant of the participant's residence.
- Accompanying the participant to clinics, physician office visits, or other trips that are reasonable for the purpose of obtaining medical care or treatment.
- Shopping for groceries or other household items required specifically for the health and maintenance of the participant.

20.5 PCS also provides:

- RN or QMRP supervision
- Case Management, if indicated, coordinates service(s) to ensure that the various needs of the individual are assessed and met.
- Some Durable Medical Equipment (DME) and Supplies. Contact local equipment vendors for coverage criteria.

Chapter 21 Traumatic Brain Injury, (TBI), Home and Community Based Services Waiver

21.1 What is the Traumatic Brain Injury Waiver?

The Traumatic Brain Injury Waiver (TBI)

In 1995 Idaho's legislature designated funds for 20 persons with a traumatic brain injury in a specialized treatment facility. In 1996 the Department of Health and Welfare released a request for proposal to the public, however no proposals came back. In October of 1997 the Department decided to write a HCBS waiver for adults with TBI.

An Implementation Team was formed to outline steps to begin the waiver. A survey was sent out to gather data. Of the 250 surveys mailed, 77 were returned. They indicated that the average age of injury was 35.2 years; 44 causes of injury were vehicular accidents; 28 lived in the family home, 28 in nursing facilities; 13 in "other" settings, and 7 received services in their own home.

The Team used the results of the survey to build the waiver.

21.2 Who does the TBI Waiver Serve?

The waiver serves participants who:

- Have a brain injury that occurred on or after age 22

21.3 What are the eligibility requirements?

- Must meet financial eligibility-income and assets at or below the limit
- Meet nursing facility level of care as determined by the Uniform Assessment Instrument
- Must meet diagnostic criteria as outlined in IDAPA 16.03.09.767
- Traumatically acquired non-degenerative, structural brain injury:
  - Anoxic brain damage
  - Intra cerebral hemorrhage
  - Skull fractures
  - Concussions

Cerebral lacerations/contusions
Hemorrhage following injury
Intracranial injury of other/unspecified nature
Late effects of skull fractures, intracranial injuries

21.4 What services are available?

- Residential habilitation
- Chore Services
- Respite Care
- Supported employment
- Skilled nursing
- Non-Medical Transportation
- Home modifications
- Personal Emergency Response System
- Personal Care Services
- Home Delivered Meals
- Specialized Medical equipment/supplies
- Extended state plan services (physical, occupational, speech therapies)
- Behavioral consultation/crisis management
- Day Rehab Services

Detailed service definitions can be found in Idaho Administrative Code 16.03.09.765 -802, "Rules Governing the Medical Assistance Program."

http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

21.5 What Provider Types can serve Traumatic Brain Injury Waiver participants?

All TBI waiver services must be coordinated through a TBI agency or a Program Coordinator:

- TBI **agencies** must sign the Medicaid Provider Agreement and the Additional Terms-Provider Agreement for Waiver Services for Adults with Traumatic Brain Injury (TBI). The agency must also insure that all direct service staff receive a Department approved TBI training program, and ongoing training, specific to the needs of the participants.
- If no TBI agency is available in the client's geographic area, the Regional Medicaid Services office may approve a **Program Coordinator** who has demonstrated experience in writing skill training programs to provide skills training and coordinate the client's TBI waiver services. The Program

Coordinator must also enroll as a TBI waiver provider and take a TBI training program approved by the Department.

Details about TBI agency and Program Coordinator requirements can be found in Idaho Administrative Code 16.03.09.796.01, "Rules Governing the Medical Assistance Program."

http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

21.6 Traumatic Brain Injury, (TBI), Home & Community Based Services Waiver
ADDITIONAL TERMS AGREEMENT:
For **TBI Waiver Agencies**, an Additional Terms Agreement must also be signed and all requirements met by the provider. (This agreement is not required for Certified Family Home Aged and Disabled Waiver Providers, Residential Assisted Living Facility Aged and Disabled Waiver Providers, and certain vendors).

Agencies will be required to write and submit specific policies and procedures, programs, and implementation plans and submit them to the Department with their Medicaid Provider Application. These documents must receive Department approval before the application will be processed and approved.

Following are selected Additional Terms Agreement sections that are further defined to assist the Provider/Applicant in assembling the required documentation:

21.7 Training: (Additional Terms Section A-3).
"The Provider shall ensure that direct service providers have taken a traumatic brain injury training course approved by the Department and have received orientation and training to meet the specific needs of the participant(s) to whom they are assigned work duties."

- The TBI Provider must contact Regional Medicaid Services to receive a list of approved TBI training courses.
- It is also the agency's responsibility to insure that all direct service providers have the necessary skills to care for specific TBI Medicaid participants safely and effectively. Before a direct service provider can be assigned to care for a participant, the Provider Agency must insure that the direct service provider has the

specific skills and competencies to meet the participant's care needs and this must be documented in the employee file. (This requirement is further defined under Additional Terms Requirement A-7.8 on page 55).

21.8 Quality Assurance: (Additional Terms Section A-5): ***"The provider is responsible for the development and implementation of a Quality Assurance Program which assures service delivery is consistent with applicable rules..."*** The Provider Quality Assurance Program must address the following:

- ***"A participant's implementation plan should be modified when there are changes in circumstances, abilities, or a re-assessment to ensure that public funds are expended for appropriate services in the most cost-effective manner,*** (Additional Terms Requirement A-5.1)"
  Define a process of participant care plan review and modification to insure accurate and appropriate care is being delivered. In addition to reporting significant increases in care needs, how will the agency insure that participant decreases in care needs will be reported to the Department. How will the Provider Agency measure quality assurance in this area?

- ***"The Provider informs each participant or guardian of the services to be received,*** (Additional Terms Requirement A.5.2)***"***
  Define the process that will be used to inform participants and/or their guardians of services the participant will receive from the Provider Agency. This process will involve the participant's review and approval of the care plan. How will the Provider Agency measure quality assurance in this area?

- ***"The Provider, its employees and subcontractors interact with participants in a respectful manner,*** (Additional Terms Requirement A.5.3)***"***
  Describe how the Provider Agency will insure that employees and subcontractors interact respectfully and professionally with Medicaid participants? The Provider Agency may develop policies and provide training in this area. This requirement might be measured during employee performance evaluations and written into subcontractor contracts. The Provider Agency might

conduct participant satisfaction surveys that specifically measures respectful and professional interactions. How will the Provider Agency measure quality assurance in this area?

- ***"Provider interventions promote participant empowerment and choice. Participants are recognized as primary decision-makers in accessing any and all services, unless an appropriate guardianship has been established by a court,*** (Additional Terms Requirement A-5.4)***."***
  How will the Provider Agency empower the participant and make them aware of their choice regarding care and service provision? How will the Provider Agency measure quality assurance in this area?

- ***"Services are provided at a time and location that is convenient, acceptable and suitable for the participant and the participant's team, and are coordinated and consistent with all other services the participant is receiving,*** (Additional Terms Requirement A-5.5)***."***
  Service delivery must be discussed and agreed upon by the participant and the participant's care team. These issues should be discussed with the participant and documented in the participant's treatment planning process. How will the Provider Agency measure quality assurance in this area?

- ***"The Provider's decision to accept or continue services for a participant is based on the provider's ability to meet the needs of the participant,*** (Additional Terms Requirement A-5.6)***."***
  The Provider will document how they will screen participant care needs to insure the Provider has resources and qualified staff to render safe and effective care to participants. How will the Provider adjust for changes in participant care need over time? How will the Provider Agency measure quality assurance in this area?

- ***"The Provider schedules services to insure that the implementation plan for this service is developed and implemented effectively,*** (Additional Terms Requirement A-5.7)***."***
  Document how the Provider will insure that the participant's scheduled care services are effectively met.

How will the provider Agency measure quality assurance in this area?

- ***"The Provider conducts a quality assurance program which includes quarterly audits of services, site visits, participant satisfaction, and annual professional credential and competency review. Provider shall implement a Quality Improvement plan for any deficiencies noted,*** (Additional Terms Requirement A-5.8)***."***
  Provider must present a written quality assurance program containing specific policies and procedures detailing the program. The procedures will define how the agency will collect quarterly data to insure that appropriate and quality services are being provided to participants. The quality assurance procedure will include documented quarterly participant home site visits and participant satisfaction surveys. Annually, the Provider will conduct credential and competency reviews to insure that employees continue to meet all qualification requirements of the program. As the Provider documents deficiencies or quality improvement needs during audits and reviews, the Provider will develop a written plan and correct or address deficiencies. All collected data and quality improvement actions will be reviewed by the Department during scheduled review.

- "***The Provider informs the participant about the participant's rights, the availability of protection and advocacy services,*** (Additional Terms Requirement A-5.9)***."*** The Provider must develop a procedure to insure that each participant is informed of participant rights, availability of adult protection services, and advocacy services. This information should be documented in participant files.

- ***"To the maximum extent feasible, the range of services must be provided by a regularly assigned employee or employees,*** (Additional Terms Requirement A-5.10)***."*** How is the Provider assuring there is caregiver consistency for participants? How will the provider Agency measure quality assurance in this area?

21.9 Financial Stability: (Additional Terms Section A-6): ***"The Provider shall provide the Department business information and evidence of financial stability and capability to fund payrolls and other business costs. The provider shall provide documentation that demonstrates the agency's business integrity…"***

- At the time of application and during subsequent reviews, the Provider agency must make available business information and evidence of financial stability demonstrating that the Provider is financially stable and capable of funding payrolls and other business costs.

- The following documentation is required:
  - A list of Corporate Officers or Principles
  - Date the Provider agency was established
  - Business ownership definition, (public company, subsidiary, partnership, etc).
  - List of employees identified by employee classification and/or type of work assignment.
  - In order to demonstrate financial integrity, the Provider must submit financial documents such as balance sheets, statements of income, statements of change in financial position, auditor's reports, and/or annual reports if the agency issues them, (submit the last 2 annual reports issued). Other financial documentation will be accepted if it adequately demonstrates the Provider agency's financial integrity.

21.10 Policies and Procedures: (Additional Terms Section A-7): ***"The provider shall provide to the Department policies and procedures…"***

- The Provider Agency will develop specific policies and procedures and attach the required documents to the Medicaid Provider application. The submitted policies and procedures will be reviewed by the Department for accuracy and appropriateness before the application will be approved. Additionally, the Provider Agency will insure that policies and procedures are reviewed and updated on a regular basis and will be reviewed by the Department during scheduled agency reviews. It is recommended that the Provider Agency have good knowledge and skills in developing and writing policy statements and procedures.

- ***"Personnel, including employee qualifications, duties, compensations, benefits, training and conduct,*** (Additional Terms Requirement A-7.1)***."*** This policy and procedure should address how the Provider Agency will insure employees meet required skills and qualifications and what the employee compensation and benefit schedule includes. Providers will develop job descriptions which specifically detail employee qualification requirements and job duties and attach them to this policy. The policy must address how the Provider Agency will insure employees receive adequate training and what the Provider Agency standards of conduct are.

- ***"Standards for acceptance of participants, intake and admission procedures, and termination of services,*** (Additional Terms Requirement A-7.2)***."*** This policy and procedure defines the standards a Provider Agency will use to determine under what conditions it will accept a participant into services. The procedure will detail specifically how the Provider Agency will admit a participant into services. The policy/procedure also describes the circumstances participant services may be terminated.

- ***"Participant's rights and confidentiality,*** (Additional Terms Requirement A-7.3)***."*** The Provider Agency should review Chapter 8 of the Medicaid Provider Orientation Guide, "Advance Directives and Participant Rights," before constructing this policy/procedure. The policy/procedure must define how the Provider Agency will insure participants are aware of their rights. The Provider Agency will attach Participant Rights and Advance Directive documents it develops or uses to the policy. Additionally, the Provider Agency must comply with all state and federal confidentiality laws. The policy will define how the Provider Agency will educate employees about confidentiality laws, and how they will insure that participants are aware of their confidentiality rights. The Provider Agency will attach Release of Information Forms and Confidentiality Notices that it develops, to include staff training materials/curriculums, to this procedure.

- ***"How the provider will maximize participant choice and involvement in the selection, scheduling, direction, and evaluation of direct service providers,***

(Additional Terms Requirement A-7.4).*"* The Provider Agency will develop a policy and procedure that specifies how the participant will be involved in planning and direction of their care. Specifically, the participant must be included in the process of selecting direct service providers employed by the Provider Agency, and development of care schedules. The policy will further define how the participant will be included in evaluating direct service providers.

- ***"Participant and employee grievance procedures,*** (Additional Terms Requirement A7-5).*"* The Provider Agency will develop a policy/procedure that outlines how employees and program participants may file grievances. The policy should describe how employees and participants are made aware of the grievance procedure, how the grievance may be reported and to whom, and what steps the Provider Agency will take once a grievance is received. The Provider Agency will define under what circumstances it will notify the Department about certain grievances and resolution actions.

- ***"Scope of service provided and procedures for delivering services. This must include how the agency will accomplish A-5.10*** (Additional Terms Requirement A-7.6).*"* This policy/procedure will define what specific Aged and Disabled Waiver services the Provider Agency will provide and how the services will be specifically delivered. The policy/procedure will also define how the Provider Agency will insure participant services are provided by regularly assigned employee or employees.

- ***"Emergency response to ensure participant health and safety. The provider must have a plan that demonstrates the capability of providing emergency back up and relief services to cover the essential service needs within a reasonable time frame*** (Additional Terms Requirement A-7.7).*"* This policy and procedure will address how the Provider Agency and direct service providers will respond to a participant emergency to insure participant health and safety are protected. Additionally, the policy/procedure will outline how the agency will insure continuity of care and service delivery, within a reasonable time frame, when emergency back up and relief services are needed.

- ***"Description of how the agency will assure that all direct service providers meet the qualifications contained in the Provider Training Matrix and Standards for Direct Care Staff and Allowable Tasks/Activities*** (Additional Terms Requirement A-7.8)***"*** A copy of the "Provider Training Matrix" and "Standards for Direct Care Staff and Allowable Tasks/Activities" forms are attached to the Aged and Disabled Waiver Provider Application. The Provider Training Matrix lists required and contingent skills and abilities for specific types of Direct Care Staff. Competency for Standards 5-25 in the Standards list must be verified by a physician, registered nurse, occupational therapist, physical therapist, or other person with a professional degree or experience in specialized areas.

  Verification of skill or knowledge can be documented in one of two ways. First, if the direct care person has previous experience delivering in-home care or has successfully completed a formal education/training program covering in-home and community based care, a detailed written or verbal explanation of the procedure can be the means of verifying competency. Secondly, if the direct care person does not have experience, then actual observation of demonstrated competency is required, meaning that the Provider Agency will insure direct care staff are able to perform care tasks that each participant they care for requires.

  The policy/procedure must document how the Provider Agency will insure these standards are met and documented.

21.11 Transition of Participants: (Additional Terms Section A-8): ***"The Provider shall develop a transition plan and provide such notice to the participant as is approved by the Department when services are being terminated."***

- The Provider Agency will develop a policy/procedure that details the process by which participants will be notified when services are being terminated by the agency. The policy will define, at a minimum, under what circumstances services may be terminated, how the participant and Department will be notified, and notification/action timeframes. The policy will further

identify how the agency will assist the participant with transition to insure that continuity of care, in certain cases, is not interrupted.

21.12 Records/Reports: (Additional Terms Section A-9): The Provider Agency is required to maintain certain records and report information on a regular basis to the Department.

- ***"Keep a list of all participants being served, and all employees, subcontractors or agencies, and submit it to the Department quarterly,*** (Additional Terms Requirement A-9.1)." The Provider Agency must submit a list of Medicaid participants that it is currently serving, and a separate employee, subcontractor/agency list to Regional Medicaid Services on a quarterly basis, (due no later than Mar 31, Jun 30, Sep 30, Dec 31 each year).
- ***"Keep progress notes/records of time, and tasks/activities performed by direct service providers and have them available to the Department during Quality Assurance reviews***, (Additional Terms requirement A-9.2)." The Provider Agency must document each item of service for which Medicaid payment is claimed, at the time it is provided. The records of these services must be kept for at least five (5) years after the date of services. The Provider Agency must provide immediate access to the records upon request from the Department, the U.S. Department of Health and Human Services or their agencies. These records may be reviewed and copied by these entities.
- ***"Keep annual evaluation reports and have them available to the Department during Quality Assurance reviews*** (Additional Terms requirement A-9.3)***."*** The Provider Agency will make all A.5 related quality assurance reports available to the Department during reviews.
- ***"Inform the Department within forty-eight (48) hours of any charges of criminal conduct, any accusation of fraudulent, negligent or abusive conduct, and any termination for poor performance by any employee, subcontractor or agent,*** (Additional Terms requirement A.9.4). The Provider Agency is responsible to inform the Regional Medicaid Services in writing when any agency employee has been criminally charged, an accusation of fraud, negligence, or abusive conduct has been made, or an employee, subcontractor, or agent has been

terminated from service or employment by the Provider Agency for poor performance.

- ***"Report any suspected or observed fraudulent, negligent, or abusive conduct to the appropriate legal authority as required by rule or law,*** (Additional Terms Requirement A-9.5)**."** Refer to Idaho Administrative Code 16.03.19.200-220 to review definitions and procedures regarding fraud, abuse and misconduct by providers and their employees. If a Provider Agency has reason to believe that fraudulent, negligent, or abusive conduct has occurred, it is required to contact the Department and other legal authority as required by rule/law, (eg., Law Enforcement, Commission on Aging, Child Protection, etc).

21.13 Subcontractors: (Additional Terms Section A-10): ***"The provider shall describe the extent to which subcontractors will be used, submit to the Department for review all contracts between the agency and its subcontractors, and have procedures in place to assure the work performed by the subcontractor is of high quality."***
The Provider Agency is responsible to develop a policy/procedure that identifies to what extent it will use subcontractors, and how the agency plans to monitor the contract, supervise, and insure that quality standards of service and care are being adequately delivered. The Provider Agency will submit copies of all subcontractor contracts and subcontractor qualifications to the Department for review.

Chapter 22 Behavioral Health Care Management for Adults with Developmental Disabilities

22.1 Behavioral Health Care Management for Adults with DD History

History:

The DD/MH Service Delivery Project was designed and implemented by the Department of Health and Welfare in response to legislative intent language drafted by the 2001 legislature. The business model was developed and a pilot project was initiated October 1, 2001 in Region II headquartered in Lewiston. The pilot addressed only developmentally disabled adults. Adult mental health was scheduled to be brought into the project after the initial pilot, but was cancelled when the pilot ended.

A Quality Improvement Council and three subcommittees were established to advise the project team that was charged with developing the pilot.

A key component to the pilot was an Independent Assessment Provider (IAP) as recommended by the Lewin Report, a study that made recommendations on ways to slow the growth of Medicaid expenditures. The Lewin Report called for an independent statewide system to assure consistent assessments and service plans for developmentally disabled consumers. The Lewin Report emphasized the importance of keeping the client assessment separate from direct service providers. The report said it is a clear conflict of interest when the same provider assesses a client's level of disability, develops a service plan to meet those needs and then provides the services.

Training for the Independent Assessment Provider began on September 3, 2001. The pilot began a month later on October 1. The pilot was to conclude April 30, 2002. At the direction of the legislature, the pilot was later extended to June 30, the end of the state fiscal year. The final two months of the pilot were completed without the Independent Assessment Provider because the IAP contract could not be extended beyond its original end date of April 30.

22.2 Behavioral Health Care Management for Adults with DD Services:

Within the regions, the bureau of care management consists of primary health services and behavioral healthcare services. These services are managed by the Regional Medicaid Managers with clear and consistent lines of communication with central office. The implementation of Adult DD Care Management leads to one common statewide process for the access, approval and review of Medicaid funded adult DD services.

The bureau of care management behavioral health unit follows a hands-on strategic plan, fostering consistent quality behavioral healthcare services within a creative team environment, which demonstrates flexibility and a proactive approach to managing care.

In order to contain the growth in behavioral healthcare costs, the Department utilizes the following techniques to control costs by setting a strong hold on policies. These techniques are the driving force behind the development of the processes and policies found in the foundation of Idaho's Behavioral Health Care Management operations.

Care Management and Utilization Management for the Department of Health and Welfare, Division of Medicaid, Bureau of Care Management, Behavioral Health Care Services Unit:

- **Care Management** techniques are used by funding sources or funding agencies to control costs by setting policies for the types of care delivered and how participants access these services. Public sector care management involves organizing an accessible and accountable service delivery system. Publicly funded resources must be flexibly deployed in order to provide *sustainable, cost-efficient,* and *effective services* to participants in their home communities.
- **Utilization Management** techniques control costs by reviewing the decision-making of a participant's care on a case-by-case assessment of the appropriateness of care prior to and during the service delivery. Two techniques are prior authorization and concurrent review.
- **Prior Authorization** is the assessment in advance of a participant's need for specific treatment based on criteria determined by the funding agency. Prior authorization

allows a health care plan to determine eligibility for services and to determine the site and intensity of the services it allows.
- **Concurrent review** assesses on-going treatments for appropriateness and progress toward treatment or service delivery goals.

The Department of Health and Welfare, Division of Medicaid, Behavioral Health Care Management business processes for adults with developmental disabilities are designed based upon the following standards:

- **Right Care**: Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement.
- **Right Place**: Services are delivered in the most integrated setting in which they normally occur based on the participant's choice to promote independence.
- **Right Price:** Cost effective services use the most integrated and least expensive services that are sufficiently intensive to address participant's needs.
- **Right Outcomes**: Services are based on assessed need, ensure health and safety and result in progress, maintenance or lack of regression for the participant.

22.3 What is a Developmental Disability?

Applicants must be determined to have a developmental disability as defined in Idaho Code to be eligible. Idaho Code identifies the need to meet criteria for both a categorical diagnosis and substantial functional limitations in 3 of 7 specified areas. Developmental disability is defined in Idaho Code 66-402 as follows:

> ***"Developmental disability"*** *means a chronic disability of a person which appears before the age of twenty-two (22) years of age and:*
>
> ***a)*** *is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and*

> ***b)*** *results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and*
>
> ***c)*** *reflects the needs for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned and coordinated.*

People previously determined to have a developmental disability, and who later succeed in developing skills to function adequately in more than four major life skill areas, may no longer meet the definition of developmental disability. Persons who have limited needs or no need for services specific to their developmental disabilities may no longer qualify for developmental disabilities services. Department staff is not responsible for the identification of all diagnoses of applicants to determine developmental disabilities eligibility; it is only necessary that documentation exists to support a diagnosis of developmental disability.

The process for Developmental Disability Eligibility Determination is completed by the Independent Assessment Provider within each geographic region. Applicants that are denied eligibility may request reconsideration by the Department through the Regional Care Manager. They may further request an Administrative Appeal Hearing if the Department also denies eligibility.

22.4 What services are available to adults with Developmental disabilities?

Once an individual has been determined to have a Developmental Disability, they must be found eligible for Medicaid assistance to receive Medicaid Paid for services. If they meet both of these criteria, they are required to have a Plan Developer who is responsible for requesting prior authorization for these services. These basic Developmental Disability Services include:

- **Plan Development/Plan Monitoring/Targeted Service Coordination** (A person can choose to be 1) be their own Plan Developer/Plan Monitor-without

reimbursement; 2) Be their own Plan Developer-Without reimbursement and have a Targeted Service Coordinator/Plan Monitor or 3) Hire one Plan Developer and one Targeted Service Coordinator –Medicaid Reimbursed (these two can be the same person or two different people-but to be reimbursed must meet qualifications and criteria for a Targeted Service Coordinator as set out in rule.

- **Developmental Disability Agency Services**: Including up to 30 hours combined developmental (Individual and Group Home/Community and Center-based) and Occupational Therapy; 25 Physical Therapy Visits a year, Psychotherapy, and Speech Therapy.

All services must have a referral for services by the participants Physician, have been assessed as needed and identified as the individuals choice in order to be prior authorized and provided to the individual.

Additional services are available to individuals who have a disability and are found eligible for the Home and Community Based Services Developmental Disability Services Waiver.

22.5 "Home and Community Based Services" (HCBS) Waivers:

When states wish to receive federal financial assistance for services provided in a community based setting for individuals who meet institutional level of care needs, the state must first obtain a waiver from the federal Centers for Medicare and Medicaid Services (CMS). Thus, Home and Community-Based Services (HCBS) waivers are options for states to fund community services provided to eligible people who would otherwise require institutionalization.

In requesting a waiver, states propose a program specific to the population they want to serve. States have the flexibility to design each waiver program and select the mix of services that best meet the needs of the population being served. In developing the proposal, states are required to provide CMS with a number of assurances before the waiver is approved. These assurances include:

- The waiver participant must be eligible for institutional level of care

- The waiver participant must meet cost effectiveness criteria (the cost of care in the home/community cannot exceed the average cost for care in an institution)
- The waiver program must offer sufficient services for a waiver participant to safely remain in his/her home

22.6 What is the Developmental Disabilities Waiver?

The Developmental Disabilities Waiver is one of the HCBS Waivers. This waiver is specific to provide community-based services to adults with developmental disabilities who would otherwise require institutionalization to be safe and healthy.

22.7 Who Does the Developmental Disabilities Waiver Serve?

The waiver serves participants who are 18 years or older and who have a developmental disability or are medically fragile. This must occur before the age of twenty two. Those participants of waiver services must insure that they can be safely maintained in their home or community with the services provided.

22.8 What are the eligibility requirements?

Evaluations or assessments that are required for determining disabilities for a participant's eligibility for developmental disabilities services must include a medical/social history and a functional assessment. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on mental retardation and they have no prior testing or prior testing is inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than mental retardation. A Scale of Independent Behavior-Revised (SIB-R) will be administered by the Department or its designee for use in this determination.

Waiver participants must meet level of care. They must be medically fragile or have a broad independence score of 8 years 0 months or a general maladaptive behavior score of -22 or less or a functional/behavior score of between 8 and 8 years 6 months in combination with a score of -17to -22 using the SIB-R

- Testing must result in substantial functional limitations in three (3) or more of the following areas of major life activity:

- Self-Care
- Receptive and expressive language
- Learning
- Mobility
- Self-direction
- Capacity for independent living or Economic Self Sufficiency

And reflect the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned and coordinated

Must need and receive a waivers service at least every 30 days.

22.9 What Services are Available?

- **Residential Habilitation** – This can be a combination of personal assistance and skill training, depending on what a participant chooses. If one lives in their own home, people can come to your home to help you. If one lives in a certified family home, the people in this home will help.

- **Supported Living Services -** consist of an integrated array of individually-tailored services and supports furnished to an eligible participant which are designed to assist them to reside successfully in their own homes, with their families, or alternate providers.

- **Chore Service** – When a participant lives in their own home they may receive help with more difficult or strenuous chores.

- **Respite Services** – When a person who gives participants the majority of care isn't paid and is gone, someone else can help.

- **Supported Employment** – Participants can have a job coach to support them at a job in the community.

- **Non-Medical Transportation** – People can be paid to drive you to places even when you don't have medical appointments. Limit 150 miles a month.

- **Environmental Modifications** – Participants can make changes to their own home that will make it easier for them to get around.

- **Specialized Medical Equipment** – Participants can get medical equipment that isn't usually available through the regular Medicaid program.

- **Personal Emergency Response Systems** – These are devices that can let emergency services know that a participant needs help right away.

- **Home Delivered Meals** – When a participant lives in their own home, agencies can deliver one or two meals a day when they are not able to cook.

- **Extended Therapy Services** - A participant can get more hours of occupational, physical, or speech therapy then the Medicaid program normally pays for.

- **Nursing Services** – A participant can get nursing services if they have certain medical needs.

- **Behavior Management/Crisis Management** – Specially trained people can help participants and their support team learn how to deal with behavioral or emotional problems.

- **Adult Day Care** – Participants who live in certified family homes can participate in a structured day program that includes a variety of social and recreational activities as well as provide supervision for safety and assistance with activities of Daily living.

- **Service Coordination Agencies -** serve adult Medicaid eligible recipients with developmental disabilities when authorized by the Regional Medicaid Services Care Manager and provided by an organized service coordination provider agency that has entered into a written provider agreement/contract with the Department. The Department will only provide Targeted Service Coordination in a geographic area where such service is not available through a private provider who has entered into an agreement into a provider/agreement/contract with the Department. The purpose of these services is to

assist eligible individuals to obtain needed health, educational, vocational, residential, and social services. Services must be in the least restrictive and most appropriate procedures setting.

- TSC's may deliver the core functions: Individual Support Plan (ISP) /Plan Monitoring which is developed in conjunction with the participant, service providers, the participant's family and /or guardian and other individuals selected by the participant. These ISP's must be developed from a person centered planning process and include information obtained from evaluations (assessments), participant interview, observation in community settings, and other pertinent information.

  The plan will be developed in order to build on maintaining and utilizing the participant's strengths and abilities. Services proposed must be built around the recipient's wants and needs: encourage the recipient to choose the locality in which he lives and works; age appropriate; included, whenever possible two (2) or more options from when the participant may choose and should be aimed at maximizing community participation, be culturally appropriate; be designed to promote and utilize natural supports and informal community supports.

  The TSC shall arrange for services necessary to execute the ISP and shall review, update and monitor the plan continuously to meet the participant's changing needs. http://www2.state.id.us/adm/admimrules/rules/idapa16/0309

22.10 Independent Assessment Providers, (IAP)

Independent Assessment Providers, (IAP), have been contracted with beginning September, 2003. Participants who have not been in the system before go the Regional Medicaid Care Manager (RCM) who does checks financial eligibility, open the participant in the DDIS System. RCM gathers HIPPA Releases and any other documentation to help establish eligibility.

- RCM then sends information gathered to an Independent Assessment Provider who administers the SIB-R, gathers psychometric testing, and information for a Medical-Social Evaluation.
- The Assessor starts a person centered planning process facilitated by the plan developer and may be comprised family and individuals significant to the participant who collaborate with the participant to develop a plan of service.
- The group includes at a minimum, the participant and the service coordinator or plan developer.
- A budget meeting is held and the participant and others at the meeting get a budget for services and will choose services dependent upon the budget.
- The budget corresponds with the support score from the SIB-R and the past three years of Medicaid expenditures, excluding, physician, pharmacy, and institutional services.
- The level of support is derived from the most current SIB-R. The level of support is a combination of the individual's functional abilities and maladaptive behaviors. as determined by the SIB-R, SIC (6) broad levels of support have been identified on a scale of zero to one hundred (0-100)

LEVEL OF SUPPORT	
Support Score Range	**Level of Support**
1-24	Pervasive
25-39	Extensive
40-54	Frequent
55-69	Limited
70-84	Intermittent
85-100	Infrequent

can Detailed service definition be found in Idaho

Administrative Code 16.03.13, “Prior Authorization for Behavioral Health Services.”

22.11 What Provider Types can serve Developmental Disabled Waiver Participants?

Providers must be a Certified Family Home (CFH), or a Certified Residential Habilitation Agency, specific waiver service providers who have signed a Provider Agreement with the Department.

CFHs are certified by Regional Medicaid Services and must meet all requirements found in IDAPA 16.03.19

http://.state.id.us/adm/admin rules/rules/idapa16/0309.pdf

Residential Habilitation Agencies must submit an application for a certificate to the Regional Medicaid Services. Forms will be provided and must contain such information as it reasonably requires, that must include affirmative evidence of ability of comply with reasonable standards and rules as are lawfully adopted by the Board. Regional Units of the Department conduct inspections and surveys and issue certificates based on the residential habilitation agency’s compliance.

http://state.id.us/adm/adm/rulesrules/idapa16/0417.pdf

Developmental Disability Agencies are any public or private organization or agency which provides developmental disabilities services on an inpatient, outpatient, residential, clinical or other programmatic basis, including community rehabilitation programs.

Before any agency, private or public, profit or non profit, can provide rehabilitative and habilitative services to persons with developmental disabilities, it must make application for licensure. No participant may receive services through an agency until the licensing agency has approved the application for licensure. No funding for services will be paid by the Department until the agency is licensed.
Services that can be provided by a developmental disability agency are: Psychotherapy, Speech and Hearing Therapy, Physical Therapy, Developmental Therapy, Occupational Therapy. Optional services include medication consultation, psychiatric advices, and Intensive Behavioral Intervention (IBI).

http://www2.state.id.us/adm/adminrules/rules/idapa14/0417.pdg

22.12 Training for Residential Habilitation Providers:

Training must include orientation and ongoing training as required under IDAPA 16.03.09. Training is to be a part of the orientation training and is required initially prior to accepting participants. All required training must be completed within six months of employment or affiliation with a residential habilitation agency and documented in the employee or affiliated residential habilitation provider record. All employees must be fingerprinted and have a criminal background check. The agency must ensure that all employees, affiliated residential habilitation providers, and contractors receive orientation training in the following areas:

- Rights
- Disabilities
- Understanding of Participants' Needs
- Supervision
- Review of Services
- First Aid and CPR

22.13 Training For Developmental Disability Agency Personnel:

Each agency designated under the rules must provide ongoing training for staff and volunteers. A minimum of twelve hours of formal training must be provided annually. Within 90 days of employment, each staff member will be certified in first aid and CPR. In addition, a minimum of twelve hours of training areas including:

- Fire safety,
- Behavior management,
- And skill development in the area of rehabilitation or habilitation of person with developmental disabilities.

Training of staff and volunteers must be sufficient to ensure the following as applicable to their work assignments and responsibilities:

1) Correct and consistent implementation of participant individual program plans and implementation plans to achieve individual objectives;

2) And optimal independence of all individuals receiving services is encouraged, supported, and reinforced through appropriate activities, opportunities and training;
3) And correct and appropriate use of assistive technology used by individuals obtaining services;
4) And accurate record keeping and data collection procedures;
5) And adequate observation, review and monitoring of staff, volunteer and participant performance to promote the achievement of participant objectives;
6) And each participant rights, advocacy, resources, confidentiality, safety, and welfare;
7) And the proper implementation of all policies and procedures developed by the agency.

22.14 Training Targeted Service Coordinator/Plan Developer/Plan Monitors:

Service coordination agencies are required for hiring and training service coordinators/plan developers and plan monitors to be qualified and capable of providing appropriate services. Individuals or family members who choose to develop their own plan will be trained by the Department one time. If they are unable to understand the requirements and process they will be informed that they will need to have a paid plan developer complete this task.

A Developmental Disabilities Training Specialist is available in each region to train all agencies and individual providers as the need arises. This support is available via the phone, internet, and in person during regular Department hours.

22.15 QUALITY ASSURANCE

Provider Internal Quality Assurance Program

All Providers of Developmental Disabilities services are responsible for the developmental and implementation of an internal Quality Assurance Program which assures service delivery is consistent with applicable rules within the scope of that service. General quality assurance must include:

1. Services provided to participants are high quality and consistent with individual choices, interests, needs and current standards of practice: This should ensure that: Criminal history checks are current for all staff;;

Ensure current evaluations of participants are in file;
Ensure current Plans are in participants file;

2. Sufficient staff and material resources are available to meet the needs of each person served that include: Appropriate education and training of staff; staffing meet needs identified on individual plans; materials are available to follow individual plans; Programs are conducted in the setting where they would commonly learn and utilize the skill.
3. Ensure services are provided in a safe and healthy environment.
4. Documentation of notice of rights and responsibilities given to participants of services including: Indication of consumer choice and satisfaction with services.

22.16 Departmental Quality Assurance

Quality assurance is a primary responsibility of the Regional Medicaid Services. Some of the goals of quality assurance in developmental disabilities services are to enhance favorable outcomes for consumers, assist staff and providers to recognize best practices, be the basis of technical assistance to increase service quality, and identify services that do not meet minimum standards.

Quality assurance includes a variety of activities. RMS staff review provider qualifications prior to approval and recommendation to EDS as a Medicaid provider to assure that agencies and individual providers are adequately prepared to begin service provision. They also provide technical assistance and training to service providers before and during the delivery of services. Quality assurance reviews, including assessments of consumer satisfaction, are another opportunity to work with providers to clarify expectations and encourage positive outcomes.

22.17 Types of Quality Assurance Reviews.

The Department is required to conduct quality assurance of all providers of Medicaid Services. For the Adult Developmental Disability Program, this includes the following provider types:

- Developmental Disability Agencies
- Targeted Service Coordination/Plan Developer Agencies
- Residential Habilitation Agencies

- Individual Waiver Service Providers: Chore Services, Behavior Consultation, Home Delivered Meals, Community Supported Employment, Nursing Services, Expanded Therapy Services (in DDA's), Adult Day Care, PERS providers (Other waiver services not mentioned are generally provided by a Residential Habilitation Agency)

1) Quality Assurance for Developmental Disabilities is required for Licensure renewal and must be completed prior to license expiration every 2 years. (See DDA Licensure and Survey Protocol)
2) Quality Assurance for all other providers should be completed every 2 years to ensure rule compliance and best practice services.
3) Complaints related to Quality Assurance: In addition to the 2 year requirement, the Department must maintain documentation of complaints and outcomes of any investigation in provider files. The Department may forward complaints about ICFs/MR or Residential Care Facilities to the Bureau of Facility Standards in the Division of Medicaid. The Department may report alleged instances of adult or child protection to the appropriate authority and may participate in, or give information about investigations. Depending on the severity of the complaint and the result of investigation, further action may be taken.

22.18 Alternative Corrective Actions

All providers mentioned above must enter into Medicaid provider agreements with the Department which require compliance with rules, define agency and Department responsibilities, and specify causes for which agreements may be terminated. When attempts to improve the quality of services through training or technical assistance have failed, staff may take other actions.

RMS staff must involve the Regional Deputy Attorney General (DAG) in all actions that set a condition of compliance on a provider for continuing the provider agreement. Written correspondence from the Department should be specific and make clear to the provider what action must be taken to maintain provider status. Information about appeal rights must accompany correspondence that threatens termination of a

provider agreement if appropriate action isn't taken by the provider.

Listed below are a variety of actions that can be taken, depending on the severity of the problem or immediacy of possible harm to consumers:

1. Delivering written recommendations to the provider. Department staff may or may not follow up on these recommendations prior to the next scheduled quality assurance review. Recommendations alone without a condition or time line for compliance are considered to be suggestive in nature and not requirements on the part of the provider for continuing the agreement.

2. Monitoring the provider at more frequent intervals than usual. For instance, if a provider is normally scheduled for an annual quality assurance review, the next review could be scheduled at 6 or 9 months. This review would be used to follow up on problems identified in an earlier review, assess progress toward remediation, and determine further action, if any. If problems have been resolved and there are indications that the provider will maintain an adequate level of service delivery, RMS staff may choose to return to a routine monitoring schedule.

3. Delivering warning or educational letters. Educational letters are only meant as technical assistance and instruction. Warning letters describe the nature of suspected violations and request an explanation of the problem and/or a warning that additional action may be taken if the action is not justified or discontinued. Warning letters should specify a date by which a response must be received by the Department and be as clear as possible in describing the problem and expected response. Information about appeal rights should not accompany warning or educational letters since no action is being taken against the provider.Where health or safety of program participants is an issue, shorter time lines of 2 weeks to 30 days are recommended. RMS staff must contact the Regional Deputy Attorney General and send a copy of the letter to Surveillance and Utilization Review Section (S/URS) staff when a warning letter is sent.

4. Medicaid providers may choose to voluntarily return Medicaid payments through S/URS when regional staff discovered services which were billed inappropriately. The provider submits adjustments for those services. A copy of those adjustments should be sent from the provider to the regional staff to verify the adjustments were submitted.

5. Immediate suspension of provider status or an employee pending the outcome of an investigation. Suspension is the temporary barring of a person or entity from participation in the Medicaid program pending further investigation or additional action. **This action can only be taken by S/URS staff**. If RMS staff feel that suspension is warranted, they need to contact S/URS staff immediately with information and documentation.

S/URS will send information about appeal rights along with notification of suspension to the provider. Providers have 35 days to appeal the decision. Providers may not receive payment until the investigation and any appeal is resolved.

Immediate suspensions may be made for health or safety risks, including suspected abuse or molestation, until those risks are assessed. The Department must provide for a hearing within 35 days of the date the appeal is received.

6. Suspension of provider payments for a period of time. Providers may continue to bill but will not be paid for services delivered following suspension of payments pending the outcome of the investigation and any appeal. **This action can only be take by S/URS staff.** If ACCESS Unit staff feel that suspension of payments is warranted, they need to contact S/URS staff immediately with information and documentation.

7. Recoupment for fraudulent billing. **This action can only be taken by S/URS staff.** If ACCESS Unit staff have reason to believe that fraudulent billing has occurred, they need to contact S/URS staff with information and documentation.

8. Exclusions. The Department can exclude persons or providers under mandatory or permissive exclusions.

Mandatory exclusions are used for persons who have been convicted of related criminal offenses or identified by HCFA (Health Care Financing Administration) as having been excluded. Permissive exclusions are used for persons or entities that have had action taken against them by a state licensing board, been identified as endangering the health or safety of a consumer, failed to disclose records or any reason for which the Secretary of Health and Human Services could exclude them under CFR, unless otherwise provided in Idaho Code. **This action can only be taken by S/URS staff.**

9. Termination of provider agreement. For regular provider agreement terminations, a provider may continue to participate in the program until the appeal rights are exhausted, so the termination becomes effective when the action becomes final. This is after 35 days when no appeal is filed.

Agreements may be terminated when providers fail to take action previously required of them by the Department within a specified period of time. RMS staff must work with regional DAGs prior to the termination. The following information should be sent to S/URS staff when regional staff terminate a provider agreement: the provider name, provider number, description of cause for the action, date of the action, and date of final action if the provider appealed. S/URS staff will take action to remove the provider status from the billing system, continue to monitor claims, and add the provider to the Idaho sanction list as a revocation of provider status.

22.19 Causes for Termination

The Department may terminate the provider agreement or otherwise deny provider status for a period of five years to any individual or entity who:

- Submits a fraudulent claim.
- Submits a false claim.
- Makes a false representation of material fact in any document required to be maintained or submitted to the Department.
- Submits a claim for an item or service which is medically unnecessary.

- Fails to provide immediate access to records or documentation required to be maintained.
- Fails repeatedly or substantially to comply with the rules governing medical assistance.
- Violates any material term or condition of the provider agreement.
- Has failed to repay, or was a managing employee or had an ownership or control interest in any entity that has failed to repay any overpayments, for claims previously found to have been obtained contrary to statute, rule, regulation, or provider agreement
- Has been found, or was a managing employee in any entity which has been found, to have engaged in fraudulent conduct or abusive conduct in connection with the delivery of health care items or services.
- Fails to meet the qualifications specifically required by rule or any applicable licensing board.
- RMS staff have the authority to terminate provider agreements based on the items noted with an asterisk, when the regional DAG has been involved prior to the action. RMS staff need to contact S/URS staff when a provider agreement is to be terminated. This allows the provider to be added to the Sanction Report. If staff have reason to believe an individual employee of a provider agency should be considered for exclusion, they should include this information when making a referral to S/URS.

The Sanction Report is distributed by S/URS on a monthly basis to Regional Medicaid Services. It contains the names of providers who have been terminated or suspended. This list is reviewed by the Criminal History Unity in Central Office when a Criminal History Check is completed. Individual provider employees may be placed on the Sanction List by S/URS depending on their individual conduct and subsequent action taken by S/URS. **Placing the name of a provider or individual on the Sanction Report can only be done by S/URS.**

22.20 Coordination with S/URS and the Fraud Unit

The S/URS and Fraud Unit addresses suspension and payment issues with providers. A referral to S/URS is appropriate for suspicion of provider abuse, misconduct, and false or fraudulent billings. Contact with S/URS will enhance efforts to avoid duplication or double action against a provider by regional. A coordinated effort between regional and S/URS staff will

increase the desired outcome of taking appropriate action with providers.

Referrals to S/URS should include the following, if possible:

- Name, address, & provider number(s) of persons under investigation or suspected of misconduct.
- Attach a copy of the provider agreements, including applications if appropriate
- A brief explanation of the nature of the complaint. If necessary, provide a background explanation of any special terms or procedures unique to the type of provider in question.
- An inventory of pertinent documentation. Include copies of all progress notes, correspondence between the Department and the provider from any and all Department units.
- A list of potential witnesses and/or informants who may be helpful in establishing the facts in a particular case.
- A summary of communications with the provider or providers in question. This may include a summary of relevant past dealings between the Department and the provider, including requests for refunds, enrollment problems, fair hearing or exemption review hearing results, rate disputes, licensing problems, etc.
- Any action that has been taken to address the allegations, such as reviewing records, talking to employees, or investigating complaints.
- Actions that staff have taken such as terminating the provider agreement.
- Names of person who received documents, date and time received and number of pages or documents.
- 10. Reasons why staff believe any individual employees should be considered for individual exclusions or further action.

S/URS staff may request regional staff participation in gathering information. It is important that these efforts are coordinated and don't result in duplicate action against a provider.

Providers have appeal rights for decisions of the Department. Contested case proceedings are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings."

Include the following activities in regular reviews:

- Contact the agency to arrange date(s) of the review and send written confirmation of the review. Send copies of checklists or guidelines that will be used during the review.
- Select the names of at least 10% of consumers whose files will be reviewed and who will be contacted for consumer satisfaction.
- Meet with agency staff before beginning the review to discuss expectations and schedules.
- Discuss operations and any questions with administrator and staff during the QA review process.
- Compare agency records to the agency QA checklist.
- Review at least 10% of consumer files. For providers with fewer consumers, a larger sample size or all consumer files may be appropriate.
- Consumer satisfaction interviews with at least 10% of people served by the agency.
- Meet with agency staff for informal, unwritten feedback.
- Optionally, request information from other customers of the agency, which may include staff in other agencies of the same or another provider type.
- Compile the Quality Assurance report with the team who conducted it.
- Send a written report to the agency with the results of the Quality Assurance review.
- Follow up as needed. Follow up activities may include training, technical assistance, corrective actions, recommendations, and recognition of positive outcomes.

Depending on availability of staff time, need for follow-up from previous reviews or complaints, and other factors unique to the provider and the regional ACCESS Unit, reviews may include other activities, such as:

- Send consumer satisfaction surveys to consumers, support team members, family members, advocates, or other interested participants. Request satisfaction assessments from other service providers who work with the agency.
- Interview a higher percent of consumers and/or interview support team members, family members, advocates, other services providers, or other interested participants.
- Program consultation for providers interested in improving the quality of their services.

22.21 Employment Services Providers

The following guidelines apply to employment providers who are reimbursed through regional contracts and Medicaid provider agreements. Employment providers must be enrolled using the DHW Provider Agreement for Employment Services and be accredited either by the Council on Accreditation for Rehabilitation Facilities (CARF) or Rehabilitation Services Accreditation System (RSAS).

While accreditation assures achievement of service standards, it does not eliminate the Department's responsibility to assure that agreements made in the provider agreement are completed. However, information from the CARF and RSAS surveys and plans of correction will be utilized as evidence to support compliance with the provider agreement. The Department maintains the ability to conduct an on-site assurance review.

Quality assurance review for employment providers will consist of the following steps:

Step 1. CARF or RSAS will be provided a copy of the Employment Services Provider Agreement and asked to include those items in their review.

Step 2: Regional staff will maintain a file for each provider that includes copies of CARF or RSAS certificate and signed DHW Employment Provider Agreement and other pertinent information from CARF or RSAS survey reports including any remediation or corrective action reports

Step 3: The Department will be invited to participate in CARF and RSAS surveys, including the entrance and exit meetings.

Step 4: Regional staff will review worker satisfaction reports and the results of any action taken following unsatisfactory reports. Information from monthly or quarterly worker satisfaction surveys will be helpful in assuring compliance with this requirement.

Once an in-depth annual worker satisfaction protocol is established, results from those worker interviews will also need to be reviewed.

While a review of the above will assure compliance with the provider agreements, efforts are to be directed to identify areas where, if needed, technical assistance/or training will help with improvement of services.

Chapter 23: Certified Family Home, (CFH), Program

23.1 What are Certified Family Homes, (CFH)?

The State of Idaho is required to certify the home of any individual who is paid to care for an adult in the individual's home, if the adult cared for is developmentally disabled, mentally ill, physically disabled, or elderly, and needs assistance with activities of daily living.

A Certified Family Home is a family home in which an adult chooses to live who is not able to reside in their own home and who requires care, help in daily living, protection, security, and encouragement towards independence.

Certified Family Homes may be certified to care for one or two persons. A waiver is available to care for a third or fourth person when the home meets certain requirements.

23.2 What are CFH certification requirements?

There are a number of certification requirements for both the home and the caregiver, and a certificate must be issued by Regional Medicaid Services before a Certified Family Home can admit adults into the home for commercial care.

A full list of certification requirements is addressed in Idaho Administrative Code 16.03.19, Rules Governing Certified Family Homes:

http://www2.state.id.us/adm/adminrules/rules/idapa16/0319.pdf

23.3 What services do CFH's provide?

Certified Family Homes provide a full array of services to adult residents who need care to include:

- Assisting the resident with activities of daily living, (the performance of basic self-care activities in meeting an individual's needs to sustain him in a daily living environment, including, but not limited to bathing,

washing, dressing, toileting, grooming, eating, communicating, continence, managing money, mobility, and associated tasks).
- Arranging for supportive services
- Being aware of the resident's general whereabouts;
- Monitoring the activities of the resident while on the premises of the home and knowledge of the resident's whereabouts to ensure the resident's health, safety, and well-being;
- Assisting residents with self-administration of medication

23.4 CFH Application Requirements

Persons interested in opening a Certified Family Home must contact the Regional Medicaid Services to obtain a Certified Family Home application and will need to meet the following requirements:

- Submit a completed CFH application along with all required documentation and attachments, (including verification that applicant has completed the Department of Health and Welfare Criminal History Check process, and has a current, valid First Aid and CPR card).
- Attend a CFH Orientation class presented by the Regional Medicaid Services office.
- And if the applicant plans to admit Medicaid pay clients to their home, the applicant must also complete a Medicaid Provider Application.